

ORIGINAL LECTURES.

VESICO-VAGINAL AND RECTO-VAGINAL FISTULA.

A Clinical Lecture, delivered at the Jefferson Medical College Hospital.

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GENTLEMEN: You will remember the patient now before you as the one presented some three weeks since suffering from a vesico-vaginal fistula. At that time, I made an examination of the opening, and described to you its size and position, being as large as a quarter of a dollar piece, and situated high up near the mouth of the uterus. You will recall that I spoke of the tense and thickened condition of the vesico-vaginal wall, and stated that it was a condition due to the opening in the bladder which had existed for so long a period. I alluded to the methods of treatment by the denudation of the edges and the introduction of sutures employed in these cases, and called attention to the fact that, in many cases, repeated operations were required to secure entire closure of the fistulous opening.

Since the patient visited the clinic, I have operated upon her, and I am gratified in being able to report that I have succeeded in closing the opening at one operation. Many difficulties were encountered, however, in obtaining this favorable result, and of these I shall speak now. In the first place, the day chosen for the operation was very unfavorable, so far as the proper light was concerned—"cloudy with partially clearing weather," as the Signal Bureau would state it, this condition affording a very uncertain light—one moment dark, and another fairly light, with varying changes from one to the other; not only uncertain was the light, but it was decidedly annoying. So many difficulties did this bad light introduce that a friend who happened into the operating-room strongly advised me to abandon the attempt at closure at that time. The patient, however, was so anxious to have the operation performed, and as I had been compelled, for other reasons, to disappoint her on one or two occasions, I decided to persevere and complete it. Under ordinary circumstances, I should adhere to the very good rule of selecting, as a day for an operation of this character, one in which the light was the best, and I should delay the operation if such was not the case.

The high position of the opening presented some difficulties which were increased by the absence of a good light. You can readily understand how much more difficult the manipulations would be which are required in using instruments in an operation upon a point high up in a tube, like the vagina, than those necessary at the orifice. Moreover, the canal was much contracted, and, for this reason, the opening could not be readily exposed.

I have referred to the tense condition of the anterior vaginal wall the result of the permanent opening in the vesical wall. This condition prevented the approximation of the edges of the opening without undue tension. In order to overcome this I made "relaxing" incisions, as they may be termed, through the mucous membrane, and after breaking up the connecting vesico-vaginal fascia slid the membrane up and in this manner relieved the tension. I was careful in de-

nuding the borders of the opening to secure an ample raw surface completely encircling it, so that the surfaces apposed after the introduction of the suture would be denuded. This is of the utmost importance in order to obtain complete union. Before introducing the sutures the edges should be brought together, and a careful examination made with regard to this point.

For the purpose of introducing the sutures I employed, as is my custom, a long-handled needle slightly curved with an eye in the point. This needle I introduced about the one-sixth of an inch outside of the margin of the denuded surface, passed it beneath the tissues through the edge of the opening, carried it across the opening into the opposite edge at a corresponding position, and in the same way brought it out at a point opposite to that of entrance. It is necessary to steady the tissues with a tenaculum, and a blunt-pointed hook will assist in the passage of the needle if placed behind its point as it emerges. The needle being held in position is armed with silver wire and withdrawn, in this manner depositing the suture without difficulty. This method of introducing the sutures in these operations I regard as possessing advantages over that of using the small vesico-vaginal needles. These needles, besides being difficult to introduce, are liable to break and thus complicate the operation. In the efforts made at introduction lacerations of the tissue also frequently occur. In this case four silver-wire sutures were introduced and clamped with perforated shot. The sutures were removed on the tenth day. A metal self-retaining catheter was kept in the bladder for a period of twelve days. On removal of the catheter the patient was able to empty the bladder, the urethra being used for that purpose the first time in thirty-seven years. At the end of the second week the patient was permitted to get out of bed, and the bowels were relieved by an enema.

The gratification which the patient expresses at the favorable result following the operation is quite manifest. She describes, in a graphic manner, the sufferings she has endured in the past thirty-seven years—"scalded in the summer" and "frozen in the winter" by the constant flow of urine. Each night she retired with a basket of dry cloths beside her bed, and during the night she was kept busy in removing the wet and readjusting the dry. Now, she passes water but four times in the twenty-four hours, and enjoys a relief from suffering, the extent of which she can scarcely appreciate.

I also present to-day three patients who have suffered with recto-labial and recto-vaginal fistulae. These lesions are caused by prolonged pressure of the child's head in parturition, direct injury, as may occur in the use of the forceps during delivery, and ulceration or abscess. Prolonged pressure and direct injury by instruments are more liable to produce vesico-vaginal fistulae, whilst ulceration is the most prolific cause of the recto-vaginal variety. Stricture of the rectum, due either to malignant or syphilitic disease, is very frequently the exciting cause of the ulceration, and should always be considered in connection with the adoption of any surgical procedures.

Inflammation occurring between the vagina and rectum, involving the recto-vaginal fascia, may eventually result in abscess, which may open into both cavities, or the abscess may gravitate towards the perineum, and

escape into the rectum, just behind the sphincter ani, and also burrow through one labium, forming a fistulous tract connecting the rectum and labium.

The symptoms presented in all of the varieties of these fistulæ are the escape of gas or fecal matter into the vagina, or through the fistulous tract into the labium. When the opening is large, the discomfort is very great, the patient having very imperfect or no control over the movement of the bowels. In simple cases, not associated with stricture or disease of the rectum, the methods of treatment are similar to those used in cases of anal fistulæ—cauterization by mineral acids and the actual cautery; nitrate of silver, either in solution or solid form, and tincture of iodine are recommended.

In larger openings between the rectum and vagina, closure may be effected by means of sutures, as in the vesico-vaginal variety, or when situated near the sphincter ani, this muscle, with the recto-vaginal wall, may be divided by the knife, or cut through with the ligature. In the case of recto-labial fistula now before us, I performed two operations—the first with only partial success. In the first operation, I employed a method described as that of the late Dr. John Rhea Barton, of this city, which consisted in the complete division of the sphincter ani laterally, and on the side of the labial opening, in this instance, as it usually happens, on the left side. The finger was introduced into the bowel, the curved bistoury carried along it and the muscle divided by cutting from within outwards. The principle of the operation you can understand, the object being to secure complete relaxation of the parts, thus permitting the walls of the fistulous tract to come in contact, and union to occur as a result. In this case, I had only partial success, owing, it may be, to a failure to divide all of the fibres of the sphincter; complete division is essential to success, and care should be taken to accomplish it. The second operation consisted in division of the wall of the fistula on the grooved director, as is practised in anal fistulæ, the parts healing by granulation.

In the two cases of recto-vaginal fistulæ, I closed one by suture after denuding the margins freely without dividing the sphincter ani. This opening was quite small, and the vaginal wall was so relaxed that no tension was exerted by the sphincter. In the other case, the opening was large enough to admit the end of the index finger, and was situated just behind the sphincter muscle. On division of the remaining portion of the perineum, it was found to contain a fistulous tract in which feces were lodged. The parts were freely cut away, so as to remove entirely the fistulous canal; the edges and borders of the opening denuded for some distance up into the vaginal tube, and the mucous membrane dissected from the inner surface of the labia, as is done in cases of perineorrhaphy, where the bowel is involved.

Silver-wire sutures, vaginal, superficial, and deep perineal—in all, fourteen—were used to approximate the parts. The quilled suture was used in bringing together the deeper surfaces of the perineum. Complete union followed in this case.

The superficial perineal sutures were removed on the sixth, the deep on the eighth, and the vaginal on the tenth day. The patient was kept on the back or side, with the limbs fastened together, for three weeks, and the bowels were opened by a large dose of oil, aided by enemata, on the nineteenth day.

In the treatment of these varieties of fistulæ, success depends in great measure, as in the vesico-vaginal forms, upon careful preliminary preparation, and, after operation, care. Where the opening is due to syphilitic disease, specific remedies should be given for some time preceding any surgical procedures.

ORIGINAL ARTICLES.

A REPORT OF A VERY LARGE SOLID FIBRO-CYSTOMA OF THE OVARY.

OPERATION FOR ITS REMOVAL; FATAL RESULT;
WITH REMARKS.

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My object in reporting the following case is not so much to show anything especially unique, either in the tumor or the operation, although the great size and peculiar structure of the former would entitle it to special interest, as to attract attention to the difficulty which exists in some conditions in making a correct diagnosis as to structure, before operating, without resorting to the expedient of aspiration or tapping as a diagnostic measure.

April 15, 1881.—M. C., colored, æt. 40 (about), called on me for the purpose of having a large abdominal tumor removed. In appearance she was decidedly larger than a woman at the full term of utero-gestation; general health fairly good, although she was losing flesh rapidly according to her own statement. She said the tumor had first begun to attract her attention about three years previously, as a very slight enlargement in the right inguino-iliac region, that its growth had been very slow until the past ten months, since which time it had been rapid—nearly all of its present enormous size had been gained within that time; the tumor had never been painful until lately, when she had suffered much from the effects of its weight, having constant backache, sharp pains in thighs and abdomen, great irritability of the bladder, hemorrhoids, alternate diarrhœa and constipation, etc. The menstrual function was still active, regular and normal in quantity and duration. Of late she had suffered much from œdema of the lower extremities, locomotion had gotten to be difficult and laborious, and she was incapacitated by her size and sufferings from pursuing her daily avocation, upon which she was dependent for a living. She urgently requested its removal.

Physical Examination.—The abdomen, upon inspection was ovoid in shape; upon palpation the tumor appeared to fill the entire abdominal cavity, its fundus reaching to the ensiform cartilage and encroaching upon the diaphragm to the embarrassment of respiration; it communicated a highly elastic sensation to the touch; *fluctuation was distinct* and unmistakable; careful percussion and auscultation confirmed the above indications of its size and character. The uterus, upon examination, was *in situ* and healthy, the sound introduced showed the extent of its cavity to be three inches (she had borne children).

Dr. John W. Sale, of Liberty, Va., then my partner in the practice of medicine, was called in consultation and agreed with me in the diagnosis, which was cystic tumor of the right ovary. Thinking the case a favorable one and conceiving that nothing was to be gained by delay, I agreed to remove the tumor, and a day in the following week